DEBATE RAGES OVER SECOND-HAND SMOKE 6 | DRUG IMPORTATION: JUST THE FACTS 14 | WASHINGTON STATE 10-11

HEALTH CARE NEWS

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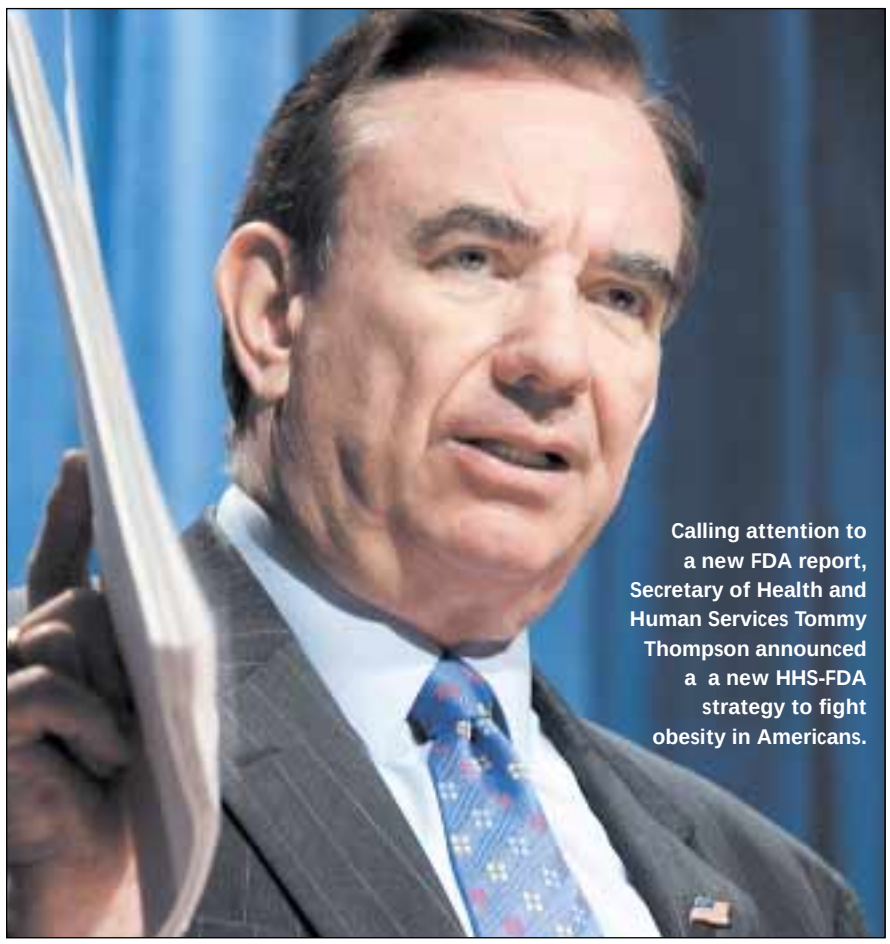
CONGRESS ACTS TO DEFUSE OBESITY TIME BOMB



Calling attention to a new FDA report, Secretary of Health and Human Services Tommy Thompson announced a a new HHS-FDA strategy to fight obesity in Americans.

UPI Photo Service

by Steve Stanek

At a March 9 news conference, Health and Human Services Secretary Tommy Thompson announced HHS will sponsor a national advertising campaign to encourage Americans to eat less and exercise more.

"The increase in Americans' waistlines is shrinking our lifelines," Thompson warned. "We've just gotten too darn fat, ladies and gentlemen, and we are going to do something about it."

The only physician in the U.S. Senate, Majority Leader Bill Frist (R-Tennessee), lauded the HHS move in a March 10 statement to the media. "I'm pleased that the CDC has addressed this growing concern, and that Secretary Thompson has taken action with a new education campaign and research agenda."

Making an IMPACT

"However, we must do more," continued Frist, who said he is especially alarmed by studies showing minorities are particularly susceptible to obesity.

The U.S. Centers for Disease Control and Prevention (CDC) last fall released

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Kerry's Rx Plan Short on Facts

by Sally C. Pipes

Sen. John Kerry (D-Mass.) punctuated his emergence as the Democratic Party's Presidential frontrunner with a drug plan he claims would lower prescription prices. "I will repeal the ban on reimporting drugs from Canada," pledged Kerry.

What Kerry left unsaid is that his plan would in fact import drug price controls, not drugs, from Canada. If Kerry's plan were enacted, it would almost surely backfire. Critical drugs would become less available—and more expensive—for Canadians and Americans alike.

In Canada, the government strictly controls drug pricing, creating artificial, below-market prices that don't reflect actual costs. The Patented Medicines Prices Review Board also determines which drugs get on the Canadian formulary—the list of drugs approved for use by Canadian citizens.

U.S. pharmaceutical companies, which develop the vast majority of cutting-edge drugs, are prohibited by Canadian law from

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Pawlenty Proposal Pfizzles at Pfizer

by Conrad F. Meier

Minnesota Governor Tim Pawlenty's attempt to threaten Pfizer with a price control resolution went nowhere at the Pfizer stockholder meeting held April 22 in St. Louis.

Pawlenty (R) and a group of protestors came to the meeting to pressure the pharmaceutical company's executives to agree to limit prices, allow U.S. consumers to buy Pfizer drugs from Canadian pharmacies, and end restrictions on exports to Canada. They left empty handed.

Shareholders Not Impressed

A shareholder's resolution drafted by Pawlenty's group would require drug companies to conduct business according to government mandates and establish practices that do not rely on "exorbitant revenue" from U.S. sales; end boycotts against Canadian wholesalers and pharmacies who resell drugs to American

PFIZER continued on page 6

HSAs Will Dominate Health Care Financing

by Stephen Parezo

Although Health Savings Accounts (HSAs) are new kids on the health insurance block, some industry experts contend the accounts could become the dominant form of health care financing in the next five to 10 years. Analysts project more than 40 million HSAs will be established over the next decade.

HSAs became available as of January 1, 2004, with passage of the Medicare reform measure signed by President George W. Bush last December. Designed to help individuals save for future medical expenses on a tax-free basis, HSAs can help build tax-sheltered nest eggs to cover out-of-pocket medical costs.

Workers below age 65 can accumulate tax-free savings for lifetime health care needs if they have qualified health insurance plans. A qualified plan has a minimum deductible of $1,000 for individuals and $2,000 for families. Individuals with

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The Problem with Price Controls

by Thomas Sowell

If you ask most people about the cost of medical care, they may tell you how much they have to pay per visit to their doctor's office or the monthly bill for their prescription drugs. But these are not the costs of medical care. These are the prices paid.

The difference between prices and costs is not just a fine distinction made by economists. Prices are what pay for costs—and if they do not pay enough to cover the costs, then centuries of history in countries around the world show that the supply is going to decline in quantity or quality, or both. In the case of medical care, the supply is a matter of life and death.

The average medical student graduates with a debt of more than $100,000. The cost per doctor of running an office is more than $100 an hour. The average cost of developing a new pharmaceutical drug is $800 million. These are among the costs of medical care.

When politicians talk about "bringing down the cost of medical care," they are not talking about reducing any of these costs by one cent. They are talking about forcing prices down through one scheme or another.

All the existing efforts to control the rising expenses of medical care—whether by government, insurance companies, or health maintenance organizations—are about holding down the amount of money they have to pay out, not about reducing any of the real costs.

Price Controls

Many of the same politicians who are gung ho for imposing price controls on prescription drugs, or for importing Canadian price controls by importing American medicines from Canada, have not the slightest interest in stopping frivolous lawsuits against doctors, hospitals, or drug companies—which are huge costs.

Price control zealots likewise seldom have any interest in reducing the amount of federal requirements for getting a drug approved for sale to the public—a process that can easily drag on for a decade or more, costing millions of dollars, and also costing the lives of those who die while waiting for the drug to be approved by bureaucrats at the Food and Drug Administration.

For political purposes, what "bringing down the cost of medical care" means is some quick fix that will win votes at the next election, regardless of what the repercussions are thereafter.

"Making a government-run medical care system mandatory—'universal' is the pretty word for mandatory—means that we will all have no choice but to be caught up in that bureaucratic maze."

What Repercussions?

If the bureaucratic hassles that doctors have to go through make their huge investment in time and money going to medical school not seem worthwhile, some can retire early and some can take jobs no longer involving treating patients. Either way, the supply of medical care can begin to decline, even in the short run.

In the long run, medical school may no longer look like such a good investment to many in the younger generation. Britain, which has had government-run medical care for more than half a century, has to import doctors from the Third World, where medical school standards are lower.

So long as there are warm bodies with "M.D." after their names, there is no decline in supply, as far as politicians are concerned. Only the patients will find out, the hard way, what declining quality means.

No law passed by more than 500 members of Congress is going to be simple or even consistent. There are already 125,000 pages of Medicare regulations. "Universal health care" can only mean more.

No Choice

I saw a vivid example of what bureaucratic medical care meant back in 1959, when I had a summer job at the headquarters of the U.S. Public Health Service in Washington. Around 5 o'clock one afternoon, a man had a heart attack on the street near our office.

He was taken to the nurse's room and asked if he was a federal employee. If he was, he could be sent to the large, modern medical facility there in the Public Health Service headquarters. But he was not a government employee, so an ambulance was summoned from a local hospital.

By the time this ambulance made its way through miles of downtown Washington rush-hour traffic, the man was dead. He died waiting for a doctor, in a building full of doctors. That is what bureaucracy means.

Making a government-run medical care system mandatory—"universal" is the pretty word for mandatory—means that we will all have no choice but to be caught up in that bureaucratic maze.

Thomas Sowell is a nationally syndicated columnist and author. ©2004. Reprinted by permission of Thomas Sowell and Creator's Syndicate, Inc.

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Medicines Are Worth the Price We Pay

by Conrad F. Meier

Just as the price of a Rolex™ watch is not solely determined by the cost of its materials, the cost of a prescription drug is not simply the cost of its ingredients.

Like other products resulting from research and creativity, medicines are really made of knowledge—a kind of intellectual property capable of preventing and curing diseases as well as relieving the pain of a headache or hip transplant. This knowledge does not come cheap. Discovering, developing, testing, and gaining regulatory approval for new medicines is expensive, time-consuming, and risky.

For every 5,000 medicines developed and laboratory-tested, only five, on average, make it to clinical trials. Only one of those is eventually approved for patient use. Revenues from the one successful medicine must cover the research and development costs of the 4,999 that don't make it to your medicine cabinet.

The average cost of bringing just one of those new medicines to market was recently pegged at $1.7 billion by Pfizer CEO Dr. Hank McKinnell.

Discovering and developing a new class of drugs now takes between 12 and 17 years. Much of that time is spent complying with self-imposed quality procedures, government regulations, and a series of strictly controlled clinical trials designed to ensure safety and effectiveness.

On average, only three of every 10 prescription drugs marketed to patients generate enough revenue to exceed the average cost of research and development.

While the cost of research and development is increasing, the amount of time brand-name drug manufacturers have to recoup their investment under patent protection laws is shrinking due to stepped-up competition from generic drugs. The clock starts ticking on patent protection when a drug first goes into research and development. For a drug taking 12 years to develop and bring to market during a 15-year patent agreement, the pharmaceutical company has just three years to recoup its investment and make a profit for shareholders.

Companies fund research on future medicines and improvements to existing medicines with revenues from medicines currently in the marketplace. On average, and according to annually published shareholder data, one dollar out of every five earned in revenue is reinvested back into research and development.

Pharmaceutical companies are currently working on more than 1,000 new medicines—for Alzheimer's, stroke, cystic fibrosis, arthritis, and many other diseases. For cancer alone, more than 400 medicines are in the pipeline.

The Value Factor

Focusing too narrowly on cutting the cost of prescription drugs may cause us to lose sight of their real and future value.

We can't easily calculate the value of a smile on the face of a child who doesn't have to feel the pain of cancer, or the stamina delivered by two hip replacements for a grandfather who delights in camping with his grandson. We can, however, quantify some of the value pharmaceuticals bring to patients, to society, and to the health care system.

Stroke–A study sponsored by the National Institutes of Health found treating stroke patients promptly with a clot-busting drug nets an average savings of $4,400 per patient by reducing the need for hospitalization, rehabilitation, and nursing home care. According to NIH, greater use of this medicine could save the health care system more than $100 million a year. (See Figure 1.)

Asthma–Increased use of asthma medications resulted in fewer emergency room visits for Medicaid asthma patients and a major cost savings for the Virginia Health Outcomes Partnership program. For patients in the demonstration program, emergency room and urgent care visits dropped by 42 percent.

Migraine Headaches–A study published in the *American Journal of Managed Care* reported the total costs of treating patients for migraine headaches declined 41 percent as the result of a new drug. Another study showed the drug saved employers $435 per month per employee due to a reduction in lost productivity costs. The monthly cost of the drug per employee was only $44. (See Figure 2.)

Congestive Heart Failure–In a year-long disease management program for about 1,100 patients with congestive heart failure, Humana Hospitals found pharmacy costs increased by 60 percent while hospital costs dropped 78 percent—for a net savings of $9.3 million. The patients' ability to perform the activities of daily living went up 15 percent, and the death rate dropped from the expected 25 percent to 10 percent.

Alzheimer's–More than four million Americans suffer from Alzheimer's disease, which is estimated to cost society $100 billion a year in medical care alone. A significant part of the cost is devoted to nursing home care. A recent study showed patients treated with a new medicine were only half as likely to require costly nursing home care as patients who didn't get the medicine.

Diabetes and Depression–According to a study published in *Health Economics* in 1996, prescription drugs helped reduce absenteeism in employees with several diseases, resulting in significant cost savings. For depression, the annual savings was $822 per employee, and for non-insulin dependent diabetes, the savings was $1,475 per employee.

Allergies–A study by the consulting firm William M. Mercer found non-sedating prescription antihistamines, though more expensive than over-the-counter medicines, cut down on lost productivity and accidents. The study found every $1 invested in non-sedating prescription medicines yielded a $3.07 return to the bottom line of a corporation due to increased productivity, decreased sick time, and reduced accident costs. (See Figure 2.)

Osteoporosis–Some 30 million Americans are at risk of developing osteoporosis, and more than 300,000 hip fractures occur every year because of this disease. Fortunately, several types of medication are available to help prevent osteoporosis and reduce the human and economic toll.

My own hip replacement surgery cost about $30,000 a little more than a year ago. A leading hormone replacement therapy, which I'm using to treat the other hip, costs about $1,500 a year.

It's not always possible to put a price tag on the value of pharmaceuticals, but experts and patient organizations have calculated the cost of leading diseases. As the population ages, the costs of caring for people with these and other diseases yet unknown will escalate—unless we come up with more cures and better treatments.

Every government proposal that impacts health care policy should be judged carefully on whether it would nurture or hurt the environment needed to continue the remarkable progress brought about by drug research.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

Figure 1: Use of Clot-Busting Drug Reduces Patients' Disability and Results in Net Savings to Health System

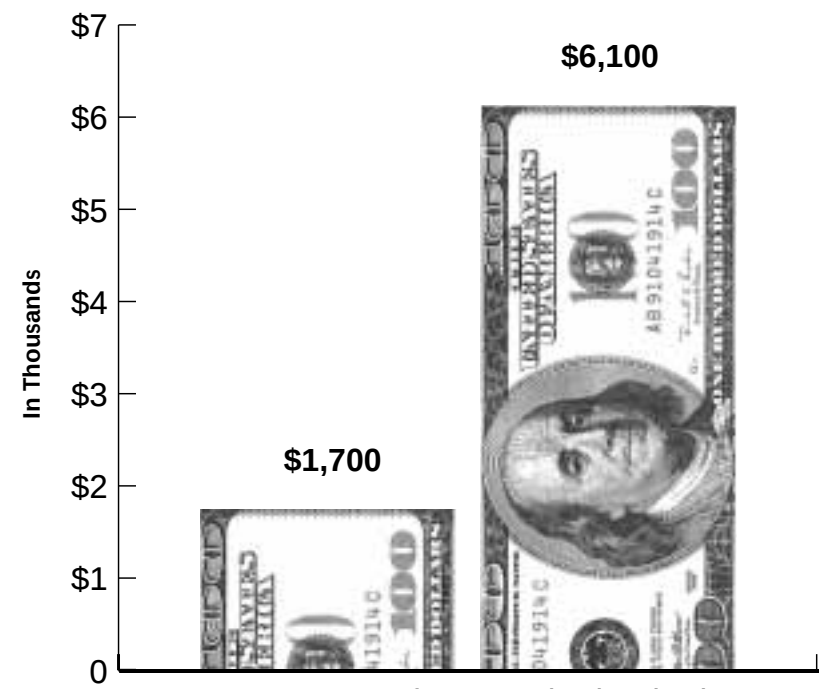
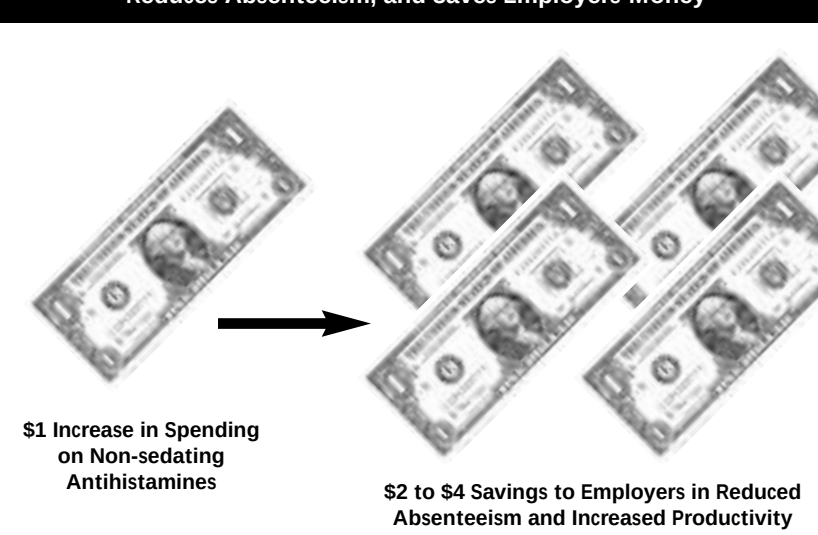


Figure 2: Increased Drug Spending Increases Productivity, Reduces Absenteeism, and Saves Employers Money


$1 Increase in Spending on Non-sedating Antihistamines
$2 to $4 Savings to Employers in Reduced Absenteeism and Increased Productivity
Source: William M. Mercer

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Our health care system and the consumers who depend on it are facing an unprecedented crisis: Costs continue to rise and the number of uninsured Americans is increasing.

As a professional association of nearly 20,0000 benefit specialists, NAHU members serve a unique role in the health insurance marketplace. On a daily basis, our membership works with both individual and corporate health insurance consumers to help provide them with the type of coverage that best serves their individual needs.

As such, NAHU members have an excellent understanding of what kinds of health insurance markets best serve consumers effectively. And after years of researching state health insurance markets nationally, NAHU has found time and time again that states that create perverse incentives for individuals to forgo health insurance coverage while driving up the cost of insurance for those who maintain it through anti-market "reforms" like guaranteed issue, mandates or community rating, have only exacerbated the growing problem of the uninsured. Conversely, states that have implemented market-friendly measures, such as high-risk pools, allowing appropriate medical underwriting, and measures that do not hinder the development of extensive health plan networks, have higher degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured.

NAHU urges all states to implement market-friendly reforms and we look forward to working with state and federal-level policymakers to ensure that our goals of reducing the number of uninsured and ensuring vibrant and competitive health insurance markets in all states are achieved.

The National Association of Health Underwriters represents 20,000 health insurance processionals across the country.
For more information, visit www.nahu.org.

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Debate Rages over Second-Hand Smoke

by Michael Fumento

Looking for a surer method of being ripped apart than entering a lion's den covered with catnip? Conduct the most exhaustive, longest-running study on second-hand smoke and death. Find no connection. And then, rather than being politically correct and hiding your data in a vast warehouse next to the Ark of the Covenant, publish it in one of the world's most respected medical journals.

That's what research professor James Enstrom of UCLA and professor Geoffrey Kabat of the State University of New York, Stony Brook did in May 2003: They reported in the *British Medical Journal* that their 39-year study of 35,561 Californians who had never smoked showed no "causal relationship between exposure to environmental tobacco smoke (ETS) and tobacco-related mortality." (They also noted "a small effect" can't be ruled out.)

At this writing, the Enstrom/Kabat work has generated more than 140 responses on the *Journal*'s Web site at **http://www.bmj.com**. If made into a movie, those responses might well be called "The Howling." Many are mere slurs several grades below even sophomoric.

Ban the Facts

Some respondents demanded the *Journal* retract the study because, as one put it, the "tobacco industry will use it." (It didn't.) Another made the rather draconian call to ban all use of statistics in science, lest they be put to such wicked purposes as this.

"It is astounding how much of the criticism springs from (personal attacks) rather than from scientific criticism of the study itself," observed one of the few supportive writers. Said another: "As a publisher of the leading Austrian medical online news service, I feel quite embarrassed following the debate on this article. Many postings look more like a witch hunt than a scientific debate."

Sadly, one of the most pathetic responses came from Dr. Michael Thun, vice president for epidemiology and surveillance research at the American Cancer Society (ACS). The ACS launched the study and formerly collaborated with the authors.

Thun claimed everybody in the 1950s and 1960s should be deemed a second-hand smoker, since smoking was so pervasive back then. That logic puts the wife of a two-pack-a-day husband in the same category as someone who once stumbled into a smoky bar. It negates *all* environmental tobacco smoke (ETS) studies based on spousal exposure—including those studies that better serve Thun's purposes.

Based on the subjects' own recollection decades later in the UCLA study, spousal smoking was indeed a good indicator of their total exposure to second-hand smoke.

Ignore the Facts

One refrain running through the attacks is, "Why take seriously a study that contradicts what everyone already knows?"

The answer is simple: Because "what everyone knows" is wrong. It's the UCLA study that's most consistent with other research.

A 1999 Environmental Health Perspectives survey of 17 ETS-heart disease studies found only five that were statistically significantly positive. ("Statistical significance" refers to whether an increased or decreased risk falls outside the bounds of what could be expected by chance.) Remarkably, Michael Thun was lead author of that study.

In 2002, an analysis of 48 studies addressing a possible ETS link to lung cancer found only 10 that were significantly positive, one that was significantly negative, and 37 that, like the Enstrom and Kabat work, were insignificant either way.

How can research find second-hand smoke to be so benign, when research shows active tobacco smoking to be so dangerous? Perhaps in part because "the dose makes the poison." We are constantly bombarded by substances proven to be carcinogens, but in tiny amounts the body usually easily fends them off. Second-hand smoke falls into this category.

A *New England Journal of Medicine* study found that even back in 1975—when having smoke puffed into your face was ubiquitous in restaurants, cocktail lounges, and transportation lounges—the concentration was equal to merely 0.004 cigarettes an hour. In scientific terminology, that's a "tiny amount."

Defund Sound Science

Unable to find significant fault with the UCLA study itself, critics repeatedly harped on what Enstrom and Kabat had clearly acknowledged: that some of the funding for the study came from the tobacco industry. As the researchers explained, the University of California's Tobacco-Related Disease Research Program, established specifically to support such research, nevertheless ceased funding for the project, and no sources outside the tobacco industry were willing to step up to the plate.

The big bucks go to those who "discover" ETS causes everything from pimples to piles. Government agencies and private organizations alike have sent tens of millions of dollars into the coffers of groups promoting ETS as a killer—even going so far as to fund research aimed at showing second-hand smoke to be more harmful than active smoking! Meanwhile, Big Tobacco has essentially extinguished its efforts on ETS, reserving new spending and political capital for other fights.

"Government agencies and private organizations alike have sent tens of millions of dollars into the coffers of groups promoting ETS as a killer ..."

So give the *British Medical Journal* and Enstrom and Kabat an "F" for political correctness. But give them an "A" for honesty and courage.

Michael Fumento is a senior fellow at the Hudson Institute and author of BioEvolution: How Biotechnology Is Changing Our World (Encounter Books). *His email address is* **fumento@pobox.com.**

Pfizer

Continued from page 1

consumers; and disclose expenditures on attorneys, lobbyists, and marketers.

The resolution missed the deadline for consideration by Pfizer stockholders. However, stockholders did vote on a proposal to ask Pfizer to detail, by September 2004, how it is keeping price increases of its most-prescribed drugs at or below the inflation rate. The measure was overwhelmingly defeated. In preliminary voting, 95 percent of the shareholders voted no.

When invited to speak, Pawlenty dropped all the previous tough talk about price-gouging and dumped his prepared remarks, choosing instead to take a moderate tone when asking shareholders to urge the Pfizer management team to allow U.S. customers to buy Pfizer drugs from Canadian pharmacies. Speaking directly to Pfizer's CEO, Dr. Hank McKinnell, Pawlenty said, "As you know there is a prairie fire that's been set across America on these issues."

Pfizer's Response

McKinnell responded saying, "Allowing Americans to re-import its drugs from Canada would be unsafe and lead to widespread drug counterfeiting." This kind of action, said McKinnell, would not necessarily reduce prices for customers in the United States. "While importing cheaper drugs from Canada looks like an easy fix," the Pfizer chief said, "the practice exposes all Americans to a rising tide of counterfeit drugs, most indistinguishable from legitimate ones."

McKinnell also said "more than 93 percent of drug development is funded by pharmaceutical companies. And the expense is growing: It takes up to 15 years and costs $1.7 billion, on average, to develop a drug." Previous estimates pegged the cost between $800 million and $1 billion.

McKinnell also told stockholders the high price of medicine in America is a trade issue. "The United States needs to act against countries that fix drug prices. Consumers in France, Germany, and Canada, among others, should share the cost of discovering and developing medicines, rather than simply reaping the rewards."

"Pfizer," he said, "is doing what it can to make that happen. We are encouraging members of Congress to recognize this for what it is—a trade issue."

The effort already seems to be producing results. A week prior to the Pfizer meeting, the Office of the U.S. Trade Representative created the new position of Assistant U.S. Trade Representative for Pharmaceutical Policy and filled it with Ralph Ives, who recently negotiated free-trade agreements with Australia and Singapore.

After the meeting Pawlenty met with reporters and said he had met with Pfizer executives earlier, saying they "agreed to disagree" on the trade issue. Yet they found common ground in the need to address foreign price-fixing. "We identified a series of trade issues that should be addressed," said Pawlenty.

The Battle Back Home

Last February, Pawlenty issued the resolution in response to moves by Pfizer to end sales to 15 prescription drug wholesalers in Canada, citing safety issues. On February 27, the Minnesota State Board of Investment voted 3-1 to approve a resolution threatening to dump $476 million in Pfizer stock from the state employee retirement program. The resolution was expanded to include AstraZeneca, Bayer, Eli Lilly, GlaxoSmithKline, Merck, and Wyeth.

Minnesota Secretary of State Mary Kiffmeyer was the sole vote against the resolution, explaining the use of "funds that belong to state employees and retirees to pressure drug companies is not consistent with the board's fiduciary duty."

David Strom, president of the Taxpayers League of Minnesota, said "it's sad to see the Board make this mistake. [The resolution] looks like a political statement, and Kiffmeyer was right to oppose it."

Outside the Pfizer stockholders meeting room, a small gathering of protesters carrying signs saying "Shame on Pfizer" was identified as part of the activist group called Minnesota Senior Federation. They are calling for a boycott of Pfizer's over-the-counter products.

Conrad Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

The Web site of The Heartland Institute offers more than two dozen documents addressing prescription drug importation. **http://www.heartland.org/PolicyBotTopic.cfm?artTopic=530.**

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Kerry

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selling their drugs in Canada at market prices. They can either sell to Canadians at a discount, or not sell at all.

Because the Canadian market for pharmaceuticals is one-tenth the size of the U.S. market, selling to Canadians at a discount is more a nuisance than a deal-breaker. But everyone can't get a discount. If U.S. pharmaceutical corporations see their drugs returning en masse to the U.S. at Canada's below-market prices, they will respond by refusing to sell drugs to Canada altogether.

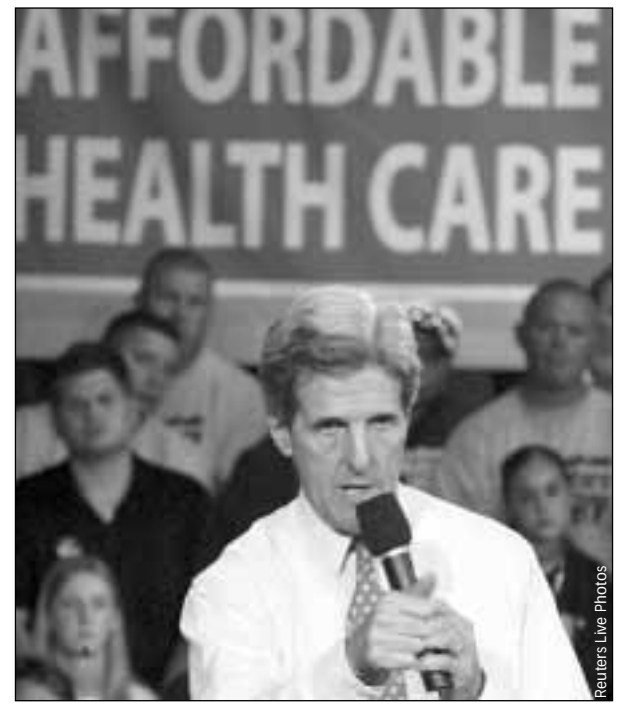
This is already beginning to happen. As more Americans use the Internet to buy drugs from Canada, pharmaceutical companies such as Pfizer, Lilly, and GlaxoSmithKline are now limiting their Canadian shipments. That means fewer advanced drugs for Canadians.

Disaster for Both Countries

Today, many Canadians travel south for life-enhancing drugs—including Embrel and Remicade for arthritis, Reyataz for AIDS, and Glucophage 2 for diabetes—that are simply unavailable in Canada. Some are available in one province but not another. Between 1999 and 2001, 100 new drugs came on the market in the U.S. Only 43 of those made it on the Canadian formulary.

That's why David MacKay, head of the Canadian International Pharmacy Association—which represents Canada's 25 largest Internet pharmacists—isn't so keen on the idea of opening Canada's price-control utopia to a flood of American consumers. He says the firms he represents don't want to build their business on the "backs of Canadians."

If Kerry's plan were implemented and America tried to piggyback on Canada's price controls, it would create an unprecedented health care disaster not just in Canada, but in the U.S. as well.



Presidential candidate Senator John Kerry (D-Massachusetts) offers an Orlando, Florida audience his plan for importing prescription drug price controls from Canada.

American companies spend an average of $800 million to develop a new drug. They must be able to recoup that investment, which is why the price of a drug is so much higher than the simple cost of manufacturing a pill. Kerry's proposal overlooks the unseen cost of research and development.

Politicians love to give away "free" stuff. But beyond the tax-subsidized fantasy world of Washington, DC, real companies go belly up everyday. It's simply not possible to fill America's medicine cabinets at below-market prices.

Think of the airlines and discount seats. If everyone were to fly in the heavily discounted seats, pretty soon there would be no seats available because the airline could not afford to fly. All passengers would lose. The same is true in the drug industry. "Cheap drugs" are good politics, but lousy economics.

Less Expensive in the U.S.

Another key problem with importing Canada's system is that price controls create bureaucracy. The last thing America's health care system needs is to get bogged down in Canada's fever swamp of rules and regulations.

Many life-saving drugs aren't available at all in Canada simply because of an overabundance of red tape. For example, approval of AIDS drugs takes twice as long in Canada as it does in the U.S.

Kerry should also note that drugs in Canada aren't always less expensive. He claims prescription prices in Canada "can be 30 to 80 percent lower for the same drug." But that is misleading, as he's talking only about non-generic drugs.

Recent FDA research finds Americans buying drugs from Canada may pay a lot more for their pharmaceuticals than they would if they had simply bought the generic version in the U.S. A 2001 Canadian study concluded 75 percent of the 27 most popular generic drugs were significantly cheaper in the U.S.

One good example is the cost of generic Prozac. In mid-January, the **PharmacyChecker.com** Web site reported one hundred 20-milligram pills sell for $13.19 in the U.S. The next lowest price in any other nation was $49.78.

That's the reality of socialist medicine. Before Kerry turns his initiative into a platform, he should call someone in Canada who's suffering from AIDS, hepatitis C, or arthritis. Take it from me—a Canadian—America doesn't want Canada's price controls ... at any cost.

Sally C. Pipes, a former Canadian resident, is president and CEO of the California-based Pacific Research Institute. Her email address is **spipes@pacificresearch.org**.

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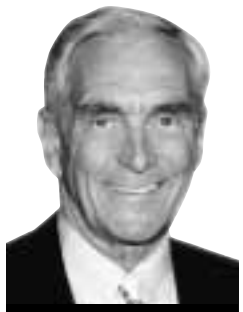
Canadian Health Care Is No Model for U.S.



by Jay Lehr, Ph.D.

When one travels through Canada, as I regularly do, one cannot help but enter into frequent discussions on the pros and cons of health care in Canada versus the United States. The quiet, self-effacing Canadians cautiously vent their discontent with a system that, while apparently free for the individual citizen, comes with many drawbacks.

From a health standpoint, the Canadian system's greatest failing is the unconscionable delay citizens must accept to obtain serious medical procedures. From an economic perspective, the costs of the system are extravagantly higher than reported by the government's suspect accounting system.

Hidden Costs

Pierre Lemieux, an economist at The University of Quebec, wrote in the April 23, 2004 issue of the *Wall Street Journal*, "The Canadian system is built around a compulsory public insurance regime that provides most medical and hospital services free." Lemieux adds that the system is not, of course, free for the Canadian taxpayer. Twenty-two percent of all taxes raised in Canada are spent on its health care system.

"[Ten thousand] breast cancer patients who had to wait an average of eight weeks for post-operative radiation treatments over the past seven years have brought a class action suit against Quebec's hospitals."

Last August, the *New England Journal of Medicine* reported health care spending absorbs only 10 percent of the Canadian gross domestic product, compared to 14 percent of U.S. GDP. The *Journal* credited Canada with being more efficient in the application of administrative costs—but the real difference is explained by the fact that U.S. citizens are permitted to pay privately for health care services, while such spending does not take place in Canada. In Canada, it is *illegal* to seek or convey private medical assistance.

Canadian health insurance is compulsory, monopolistic, and administered by the various provincial governments under strict control of the federal government. It is illegal for a Canadian citizen to carry private insurance coverage for any health care services covered by the government. Physicians are told by the government how much they can charge for their services; drug prices are set by the government. The supply of medical services in Canada is completely rationed, with no significant private alternative.

The alleged "low cost" of Canadian health care is thus no less a fraud than it was in the Soviet Union. Canadians may not pay the price in dollar terms ... but they pay a steep price indeed in terms of care denied or delayed and the poor quality of service provided by unhappy medical practitioners whose incomes do not match their skill and training.

Take a Number and Wait

Long waiting lines are the worst flaw in the system. The Fraser Institute, a Canadian think tank, calculated in 2003 the average Canadian waited more than four months for treatment by a specialist once the referral was made by a general practitioner. According to the Fraser Institute's work, the shortest median wait was 6.1 weeks for oncology (cancer) treatment without radiation. In some provinces, neurosurgery patients waited more than a year. A simple MRI requires, on average, a three-month wait in Canada.

Long waits for critical care are an uncalculated cost of the Canadian health care system. A price tag could easily be calculated by determining how much patients would be willing to pay to reduce or eliminate these waiting times. We do this calculation on a regular basis in the United States in determining the charges for all services provided. In the U.S., we choose to pay higher prices in order to get more immediate care; in Canada, patients have no choice but to wait.

Three-Tier System

My own personal contacts with Canadians support a recent article in the *Montreal Gazette*, in which a Canadian woman described the frequent rudeness of unionized Canadian medical staff as compared to the "kindness, discretion, and professionalism" of staff members in U.S. hospitals. Few Canadians can afford to experience health care in the U.S. and thus make this comparison.

In his *Wall Street Journal* article, Lemieux quotes Professor Livio Di Matteo of Lakehead University in Ontario describing a three-tier system of health care in Canada. The very rich, DiMatteo pointed out, can go to the U.S. for rapid, personalized, high-tech treatment. A second tier, consisting of well-informed, aggressive Canadians, knows how to navigate the government system to gain every possible advantage, like getting to the head of the queue.

The third tier are the unconnected citizens, who make up the vast majority of patients in the Canadian health care system. They must suffer the slings and arrows of a system notoriously oblivious to anguish, discomfort, humiliation, and other affronts perpetrated by unfeeling bureaucrats on patients whose pain is most definitely not felt by those in charge.

A Quebec physician, Dr. Jacques Chanoulli, is suing the Canadian government for not allowing patients to pay for better care. The Supreme Court of Canada will hear the case in June. At the same time, 10,000 breast cancer patients who had to wait an average of eight weeks for post-operative radiation treatments over the past seven years have brought a class action suit against Quebec's hospitals.

Free-Market Alternatives

The demand for better health care has spurred innovation in Canada and overseas.

Two Indian nations, for example, are planning to build private hospitals on tribal lands, where the Canadian government's laws do not apply.

Private hospital companies in India are seeing tens of thousands of patients a year from outside that country's borders. The largest of these firms, Apollo Hospital Enterprises Ltd., has seen 60,000 foreign patients in the past three years. Terry Salo, a Canadian resident of Victoria, British Columbia, availed himself of hip replacement in Madras, India after waiting more than a year for the "free" service in his home province.

Similarly, Thailand, Malaysia, and Singapore have taken the lead in the field of "medical tourism," supplying low-cost, high-quality procedures to more than 600,000 patients in 2003. An article in the May 3 issue of the *Chicago Tribune* reported Poland's entry into the field, encouraging travelers to seek out lower-cost dental care while visiting Poland.

Kerry Would Clone it

What is happening in Canada and other countries with socialist health care systems is relevant to the current political debate in the U.S.

Michael Cannon, director of health policy studies for the Cato Institute, reported on the group's Web site that Democratic Presidential candidate John Kerry's health insurance proposals amount to sweeping socialization of the U.S. health care system.

That ought to alarm Americans, who should have no interest in seeing their health care deteriorate to the level of Canada's "free" system.

Dr. Jay H. Lehr is science director for The Heartland Institute. Lehr frequently travels to Canada and has spoken before more than 1,000 audiences on topics ranging from global warming to nuclear energy. He is editor of Rational Readings on Environmental Concerns*, a 900-page textbook now in its third printing. His email address is* **e3@e3power.com**.

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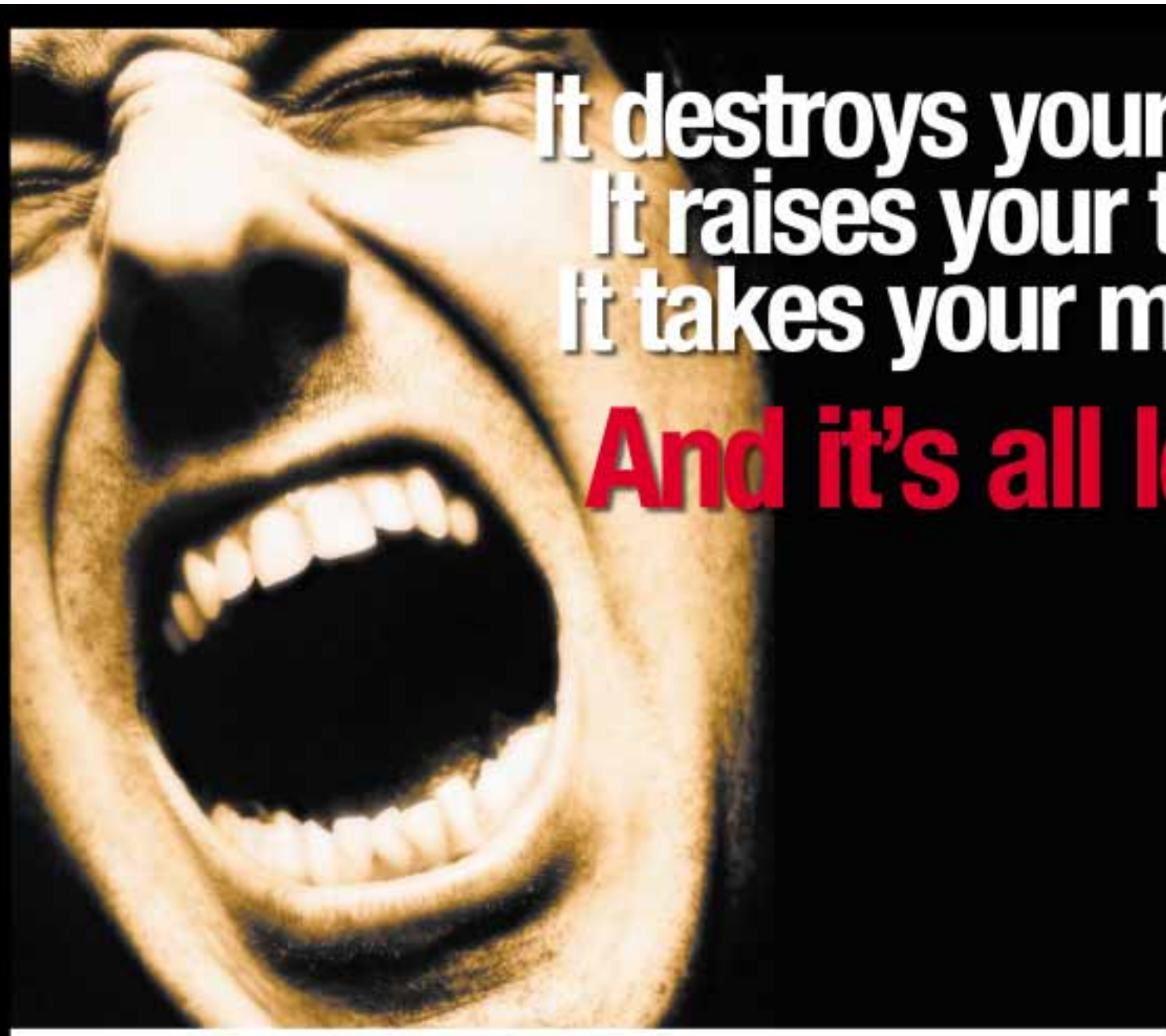

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* A December 2003 Tillinghast Towers Perrin study estimated the cost of the U.S. tort system to be $233 billion in 2002, or $809 per U.S. citizen.

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UPDATE

WA Hopes to Recover from Failed Reforms

by Conrad F. Meier

Before Washington Governor Gary Locke (D) signed HB 2460 in March, the state defined "small group" as any employer group with 1 to 50 employees. That allowed individuals to set themselves up as a single-person business, thus qualifying for small group rates on guaranteed-issue policies, which allowed them to "game the system" by dropping in and out of insurance as it served their purposes. Insurers, required to issue community-rated coverage regardless of the applicant's health status, were left holding the bag.

To address the situation, HB 2460 redefines a small group as any employer group with 2 to 50 employees, thus establishing a clearly defined market for individual insurance. The move is expected to make the state more attractive to insurers who specialize in the individual market.

Paul Guppy, vice president for research at the Seattle-based Washington Policy Center, agreed the measure would help stabilize the state's individual insurance market. But he also told *Health Care News*, "The governor and legislature missed a major opportunity to make health care insurance more affordable for the small group market, and HB 2460 does absolutely nothing to address the high uninsured rate in the state."

The National Federation of Independent Business (NFIB) also contends the new law falls short. In an April 9 news release, Carolyn Logue, Washington state director for NFIB, noted, "HB 2460 only helps insurance companies and does not provide low-cost health insurance options for small business."

NFIB has teamed up with the state's Independent Business Association and the Washington Association of Health Underwriters to launch an initiative campaign, numbered I-895, that will place on the November ballot a referendum allowing insurers to offer a basic health care plan to small businesses free of mandates. The groups had supported an alternative to HB 2460 that passed the state senate in March but failed to pass the state house.

Signatures are currently being gathered for the I-895 ballot initiative. Among other reforms, that measure would give insurers more leeway in community rating, to allow for greater price flexibility, and allow them to provide a variety of plan options. That,

Governor Gary Locke (D)

says the initiative's supporters, would allow consumers to purchase plans more closely tailored to their needs.

The initiative also would permit small businesses to purchase the basic health care plans mandated by the state even if they have provided coverage before or if they currently offer better coverage to their employees. This, NFIB notes, "would make the [basic] plans a true safety net for those small businesses who can no longer afford their current coverage and who may drop coverage all together if a less-expensive plan is not available."

NFIB and policy analysts also recommend the state legislature avoid passing new mandated insurance benefits and embark on a thorough review of existing benefits. Notes NFIB, "only in this broader context can a decision be made about how these mandates are impacting public health and health insurance costs."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

For more information on the NFIB ballot initiative and health care reform agenda, visit **http://www.nfib.com**. Select Washington in the state list, select "Go to the Washington State home page," and click on Health Care in the NFIB/Washington Agenda list.

Washington Still Su from Clinton-Care I

On March 31, Washington Governor Gary Locke (D) signed into law HB 2460, an act that redefines a small group as any employer group with 2 to 50 employees. But the small group reforms contained in HB 2460 only begin to undo policy failures adopted in the early 1990s by Washington state legislators and then-Governor Mike Lowry (D).

Clinton-Care Reforms

In September 1993, Lowry signed the Washington Health Services Act (WHSA), a sweeping measure not unlike the Clinton administration's proposal to nationalize the country's health care system. Indeed, Lowry all but took credit for the Clinton plan, saying, "I am pleased President Clinton's reform proposals so closely resemble Washington State's new law."

State Representative Phil Dyer, ranking minority leader on the Health Care Committee at the time, said, "I watched the passage of a bill that was constantly being revised with [area code] 202 fax headers—the latest wisdom from Washington, DC—coming into the caucus, because in that Spring of 1993, the Ira Magaziner [health care] task force had been formed, and was, in fact, operating."

As if sending a warning to the rest of the nation, a solidly liberal Washington state legislature eventually passed individual health insurance reform that included key elements of the original Clinton plan:

- Insurers were required to guarantee issue insurance.
- Insurers were required to offer a Basic Health Plan covering a government-defined set of benefits. Insurers were permitted to offer other plans, including plans with fewer benefits.
- Insurers were required to use a modified community rating scheme, allowing premium variations only for geography, age, family size, length of time with insurance from that company, and wellness.
- Insurers were permitted to adjust premiums only annually, except in cases where the insured's family composition or benefits choice changed, or if laws were passed that would affect premiums.
- Insurers were permitted to exclude coverage of preexisting conditions for only 90 days prior to the effective date of insurance coverage.
- The state department of insurance was given authority to approve or disapprove all insurance-related regulatory actions, including actions on rate increases, benefit designs, community rating parameters, and guaranteed issue provisions.

Implementation

Implementation of the WHSA was left in the hands of Insurance Commissioner Deborah Senn. Washington is one of only a few states where the insurance commissioner is an elected position, and Senn's efforts on the WHSA initiative often seemed to reflect her need to "campaign" for popularity among voters.

Early in 1994, Senn and a group of insurance company officials announced at a news conference the first step of her plan: a three-month open-enrollment period beginning in July 1994. During that period, any of the state's 600,000 uninsured residents could apply for individual insurance policies at community rates mandated by state law, which the insurers guaranteed they would issue. State actuaries estimated the reforms would raise overall insurance rates by only 3 to 5 percent, with no single insurer carrying the bulk of the cost.

The success of the WHSA hinged on the ability of insurers to spread the cost of the new enrollees, many of them considered high-risk for health insurance purposes, among the state's 4.4 million policyholders. To do that, Senn needed approval from the state legislature and a congressional waiver of regulations that would otherwise exclude from the state's cost-sharing program 1.4 million Washington residents whose employers were self-insured under ERISA.

During the open enrollment period, thousands of formerly uninsured Evergreen State residents signed up. With the prospect of thousands of new customers and only modestly higher costs, some insurers eagerly took advantage of open enrollment. One of the state's major insurers, Pierce County Medical Bureau Inc., began signing up enrollees several months before the official start of the program and added some 6,000 customers. Principal Mutual signed up 2,200 enrollees, increasing its roster of individual policyholders by more than a third.

Reforms Begin to Unravel

It wasn't long, though, before the WHSA began to unravel.

After the 1994 election, the new Republican-dominated Congress, fundamentally opposed to Clinton-style health care reform, refused to waive the regulation that excluded people in company self-insured programs from the state's cost-sharing program. Without that waiver, Senn had 1.4 million fewer policyholders to absorb the cost of her new effort.

In 1995, the state legislature repealed most of the cost-sharing provisions that had made the WHSA palatable to the state's insurers. Legislators did not, however, lift the open enrollment provision or the guaranteed issue and community rating mandates.

With insurers' rolls over-flowing with new,

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Suffering e Experiment

by Conrad F. Meier

UPI Photo Service

often high-risk policyholders and no way to spread the cost, the bills began to pile up.

Pierce County Medical said its monthly medical costs for individual policyholders soared 67 percent in the first year to nearly $100 a month, up from about $60. Its 6,000 new policyholders cost even more—an average of $131.44 a month, according to John Holtermann, the company's chief operating officer. The company was paying about $1 million a month more in claims against individual policies than it was receiving in premiums.

Principal Mutual fared even worse. Its generous plan drew some of the highest-risk enrollees. By 1995, the Des Moines, Iowa insurer logged about $32 million in health insurance claims in Washington State alone, but raised just $20 million in premiums—nearly twice the average cost of its claims elsewhere in the U.S.

Insurers Seek Rate Increases

Insurers doing business in Washington's individual market began filing for big rate increases to cover the soaring costs. During the 1995-1996 rating period, Blue Cross of Washington and Alaska filed for a 19 percent increase for 80,000 individual policyholders. Pierce County Medical wanted a 34 percent boost on its individual policies. Rate increases were denied. Principal Mutual notified Senn's department it planned to stop writing individual health insurance policies altogether.

Senn said insurers deliberately tried to sabotage her efforts. Insurers denied the accusation, noting Senn threw open the state's insurance rolls before cost-sharing was in place. Rep. Dyer said of Senn, "She had no technical expertise in this area. She just wanted to rush in and make people happy."

Some state legislators tried to undo the damage. Republicans and Democrats alike offered bills during the 1996 session to raise funds to cover the spiraling health insurance claims. The bills were rejected.

As Bill Baldwin, president of the Washington Institute for Policy Studies, noted in 1997, "The market for individually-purchased health insurance in Washington is 'hemorrhaging,' 'bleeding,' and 'in jeopardy.' This bad news has meant: rising costs, double-digit premium increases, declining enrollment, carrier losses in the millions of dollars every year, increasingly stingy plans, and fewer carriers from which consumers can choose."

Consumers Flee Individual Market

The *Puget Sound Business Journal* reported in November 1997 that some 14,000 state residents had dropped their individual health insurance during the first half of the year. That followed an even steeper decline in 1996, when nearly 40,000 policyholders insured by the state's largest health insurers allowed their policies to lapse.

Through 1999, state legislators tried incrementally to address the problems caused by the 1993 law. With every adjustment, new problems arose. Even after a more conservative legislature repealed some elements of the early legislation, major portions remained intact.

"Washington's health care financing mess will not blow over in a day, and the worst is yet to come. The financial burdens on doctors and hospitals, as they struggle to maintain full services with dwindling resources, pose a real threat to all Washington residents at all social and economic levels."

DR. PETE MCGOUGH AND GEORGE SCHNEIDER M.D.

In September 1999, Dr. Pete McGough, medical director for Providence Health Center in Redmond, and George Schneider M.D., part-time professor at Washington State University, wrote in the *Seattle Post-Intelligencer*, "Washington's health care financing mess will not blow over in a day, and the worst is yet to come. The financial burdens on doctors and hospitals, as they struggle to maintain full services with dwindling resources, pose a real threat to all Washington residents at all social and economic levels."

"By now," McGough and Schneider continued, "every major health insurance carrier has dropped out of the individual insurance market."

Group Health and Regence Blue Shield left, leaving individuals and families in 32 of the state's 39 counties without private individual health insurance options. To make matters worse, officials for Basic Health Plan (BHP), the state-run "safety net," announced the plan would not accept new patients after January 2000. At the same time, State Senator Pat Thibaudeau (D-Seattle) announced roughly 11 percent of the state's population was uninsured—about 600,000 residents, as many as were uninsured when the WHSA reform was adopted in 1993.

In 1993, roughly 880,000 individuals and families in Washington State were insured in the individual health insurance market. By 1998, the number had dropped to 513,000. (The figure has since climbed to 653,000 in 2001 as legislators adopted new reforms.)

Between 1993 and 2001, the number of Washington State residents insured by taxpayer-funded Medicaid increased by nearly 70 percent, from 405,000 in 1993 to 685,000 in 2001.

Before the WHSA, 30 insurers sold individual health insurance in Washington. Today there are seven: Premara Blue Cross, Regence Blue Shield, and Group Health Plan of Puget Sound (the three dominant providers), plus Regence Blue Shield of Idaho, Regence BCBS of Oregon, KPS Health Plan, and Premara Lifewise Health Plan.

High-Risk Response

In late 1999, Insurance Commissioner Senn reopened the state's high-risk health insurance pool to anyone seeking individual health insurance in counties with no private options. But few could afford to participate; as is true of most state-run high-risk pools, premiums for those enrolled in the pool were capped at 125 percent of average premiums if they chose the managed care option, and 150 percent of average if they chose the fee-for-service option.

In November 1999, a low-cost managed care plan was added to the risk pool for all counties where private insurance companies had been regulated out of business. Because most residents had access to that new low-cost option (32 of 39 counties had no private individual health insurance options), and because the guaranteed issue mandate meant they could not be denied entrance to the pool, healthy consumers were encourage to "game" the system by signing up for insurance only when they needed hospitalization, prescription drugs, or maternity care, exiting the pool when the medical event passed.

This created problems for the high-risk pool no different from those that had developed in the private health insurance market. For example, the April 5, 1996 issue of the *Wall Street Journal* reported,

"A [Washington State] woman wrote to her insurance company congratulating them for their excellent maternity care while having her first baby. She had been uninsured, but signed up after she got pregnant. Now that her baby was born, she was canceling her policy, but assured the insurance company she would come back if she ever got pregnant again."

Road to Recovery

In 2000, Governor Locke, determined to restore a competitive individual health insurance market, signed SB 6199, a bill that put Washington on the road to recovery. Under the new law:

- Insurers were allowed to return to risk-based underwriting. Persons who applied for individual health insurance but could not pass a health screening were allowed to apply for insurance in the high-risk pool.
- Premiums were still subject to modified community rating, but the Insurance Commissioner no longer has rating authority. Instead, the insurer must meet a 72 percent loss ratio standard. Under the new arrangement, an insurance company can get approval for a rate increase if it can document it is losing money on claims experience.
- The guaranteed issue mandate was adjusted to allow insurers to exclude coverage for preexisting conditions for up to nine months.
- An employee who loses his or her job through no fault of his or her own is entitled to guaranteed-issue health insurance after all other sources (such as COBRA) are exhausted. Once those options are exhausted (or if the person had no such options to begin with), he or she has 63 days to sign up for an insurance policy, and that policy cannot be denied. This portability provision made Washington state law consistent with federal law.

Into the Future

The reform steps taken by Washington state policymakers in 2000 and 2004 have been in the right direction. Today, all counties report at least two insurers offering individual health insurance polices.

But, as the state's business groups and policy analysts have made clear, the state has a long way to go before it has undone the damage caused by the 1993 reform experiment.

Next (in August; July is a scheduled "skip month" for Health Care News*): Massachusetts.*

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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Doctors and Patients Benefit When Insurers Are Bypassed

by Greg Scandlen

The Joint Economic Committee of Congress held a hearing in April on "Consumer-Directed Doctoring: The Doctor Is In, Even if Insurance Is Out."

Among the witnesses were Robert S. Berry, MD of the PATMOS EmergiClinic in Greeneville, Tennessee; Alieta Eck, MD of the Zarephath Health Center in Zarephath, New Jersey; Bernard Kaminetsky, MD, FACP of MDVIP in Boca Raton, Florida; and Robert Berenson, MD of the Urban Institute in Washington, DC.

Chaired by Senator Robert Bennett (R-Utah), the committee has been holding a series of hearings on cutting-edge developments in health care, especially on how consumer choice is revolutionizing American medicine.

Doctors Are Frustrated

Bennett began the hearing by pointing out "many doctors are frustrated by the state of our current health care system," and especially frustrated by "third-party entities interfering in their practice, pushing them toward a system that focuses on arcane regulations, not on patient care."

Bennett said the hearings will examine the experiences of innovative and entrepreneurial doctors who are responding to gaps in the current system by returning to a consumer-directed style of medical practice.

He added the "early evidence of consumer-directed doctoring suggests that some physicians and patients are reacting favorably to this way of providing care."

Dr. Robert Berry

Berry testified his clinic focuses on "the unique needs of the uninsured [who are] the most cost-effective health care consumers." He used to be an emergency room physician and found many of his patients who came in for routine services are "neither destitute nor derelict." Rather, they are hard-working people who pay their bills and resent how they are treated in government clinics.

Berry posts his prices in the clinic and in advertising—$25 to treat poison ivy, $35 for a sore throat, $95 for a simple laceration. He said, "The only way I can keep my prices so low is by avoiding the crushing overhead and hassles that other physicians allow third-party payers to impose on their practices." He currently has nearly 5,000 patient charts, of which 51 percent are uninsured (a statistic that helps to show the "uninsured" do not necessarily go without health care). Of the remaining patients, 38 percent are commercially insured, 8 percent are on Medicaid, and 3 percent are on Medicare.

Berry said he is not alone in what he is doing and cited many other physicians across the country who are taking similar paths.

Dr. Alieta Eck

Eck testified that in her state of New Jersey it is virtually impossible to buy health insurance unless your employer provides it for you. Due to misguided state regulations, the premium for even modest coverage for a single person ($1,000 deductible and 70/30 coinsurance) ranges from $912 to $4,419 a month. (See "The New Jersey Care Wreck," *Health Care News*, February 2004.)

The number of people in New Jersey with individual insurance has plunged from 220,000 in 1996 to 90,000 today. In that environment, Eck said, there are plenty of people who can afford to pay for medical care, but cannot afford health insurance.

Eck's four-doctor practice takes no insurance except Medicare, and it employs only one full-time employee, a bookkeeper, and six part-time nurses and receptionists. This is quite a contrast from the five-to-one ratio of full-time employees per doctor prevailing across the country. Her testimony cited many examples of patients who have benefitted from the services she provides.

Dr. Bernard Kaminetsky

Kaminetsky said he joined MDVIP (MD for doctor, VIP for very important patient) "in order to provide my patients with comprehensive preventive care services that unfortunately can no longer be offered in a traditional primary care setting." He said when managed care came along it distorted medical practice by paying so little physicians had to rush patients through the visit, precluding the time it takes for a preventive approach to their medical needs.

He pointed out that in a typical managed care practice with 2,500 patients, one would have to work 50 hours a week for 50 weeks to provide each patient with a comprehensive hour-long physical exam—leaving no time at all for acute care needs. He joined MDVIP to get his caseload down to 600 patients and offer more time for each patient.

Dr. Robert Berenson

Urban Institute's Berenson provided the only sour note, arguing fee-for-service practices such as the doctors described hinder cost containment efforts and "exacerbate current problems with access to services for the uninsured and underinsured." While he acknowledged the frustrations physicians face, he believes those frustrations "represent symptoms of a system lacking universal, comprehensive health care insurance." He concluded that "at its best, providing substantial health care services for much of the population outside of insurance is an elitist notion."

The discussion after the testimony was largely friendly and productive, with even Congressman Pete Stark (D-California) agreeing there is merit to the approaches described by Drs. Berry, Eck, and Kaminetsky.

Stark's one concern was whether consumers are sufficiently informed to shop effectively for medical services the way they can shop for other services. But the witnesses did a lot to reassure him on that point.

Source: You may link to the testimony of these witnesses and others at the Galen Institute's Web site, **http://www.galen.org/ownins.asp?docID=633**.

SimpleCare Concept Taking Hold

The magazine *Medical Economics* picks up on the fee-for-service trend in an article headlined, "No Coding, No Insurers—No Kidding." Senior Editor Robert Lowes writes, "It might be time to consider a cash-only practice. Your income may drop, but your overhead will decrease and your job satisfaction could soar."

The Nirvana is described as "No more arguing with insurance clerks about denied claims. No more fears of a Medicare audit." The article cites Dr. Rick Baxley of Orlando, who dropped all insurance contracts in 2000 and reports, "I earn roughly what I did back then, but I'm not working from 6 a.m. to 9 p.m. anymore. And I'm building relationships with patients, which is why I entered medicine in the first place."

Bethesda, Maryland internists Jane Chretien and Audrey Corson say they "have extended the length of the average visit from 8 minutes to about 25 minutes." They maintain, "When visits are longer, you get to know your patients. You can put their complaints in a bigger context."

Dr. Vern Cherewatenko, originator of the SimpleCare concept, is quoted as saying "a cash-only soloist probably can operate with just a receptionist and a medical assistant."

The article provides some advice for physicians thinking about moving in this direction: Cut ties with insurance companies gradually, starting with the worst payers; drop Medicare last, especially if you have a large number of patients on Medicare; and "be prepared to scramble initially to make ends meet."

Source: **http://www.memag.com**

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *His email address is* **gmscan@aol.com**.

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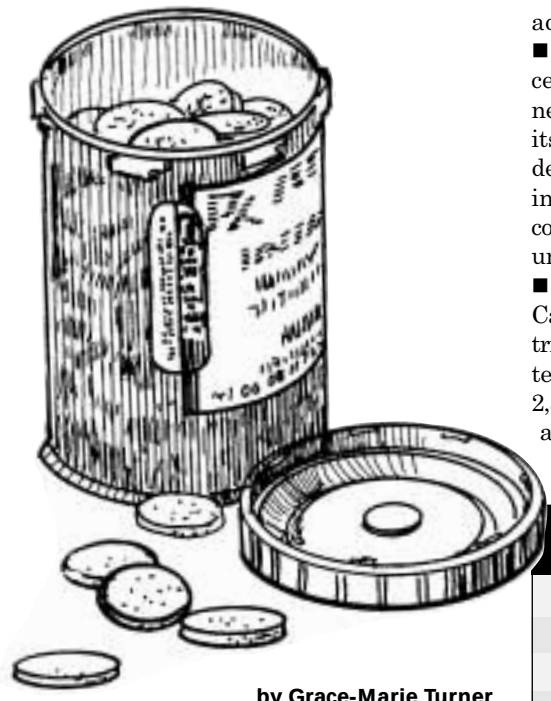
Prescription Drug Importation: Just the Facts

"[An FDA] inspection blitz in November 2003 at mail facilities ... revealed similar problems: 1,728 unapproved drugs among the 1,982 parcels inspected."



by Grace-Marie Turner and Conrad Meier

Election-year rhetoric is threatening to bury the real facts about prescription drug importation. The following facts are indispensable to understanding what is really at stake in the debate.

Imported Drugs Often Unsafe

■ The Food and Drug Administration examined mail shipments of imported drugs flowing through Miami, New York, San Francisco, and Carson, California to U.S. consumers in July and August, 2003. It found the packages often contained dangerous, unapproved, or counterfeit drugs. Eighty-eight percent of the drugs examined did not meet FDA standards.[1]

■ A second inspection blitz in November 2003 at mail facilities in Buffalo, Dallas, Chicago, and Seattle and courier hubs in Memphis and Cincinnati revealed similar problems: 1,728 unapproved drugs among the 1,982 parcels inspected. The unapproved drugs included "foreign versions" of FDA-approved drugs, recalled drugs, drugs requiring special storage conditions, drugs requiring close physician monitoring, and drugs containing addictive controlled substances.[2]

■ Canada makes only a very small percentage of the prescription medicines it needs for internal use and gets the rest of its supply from around the world.[3] Rising demand from U.S. consumers is causing increased shipments into Canada from countries with a history of counterfeit and unsafe drug production.

■ Between 2002 and 2003, drug imports to Canada rose dramatically from other countries noted for their high rates of drug counterfeiting.[4] (See table.) There has been a 2,372 percent increase in imports from Iran and a 3,270 percent increase in imports from Brazil, for example.[5]

Increase in Canadian Imports, 2002- 2003	
Bangladesh	1,336%
China	439%
South Africa	389%
Turkey	160%
Philippines	140%
Saudi Arabia	90%

■ When asked about the potential impact of U.S. pharmacies limiting shipments to Canadian pharmacies, a Canadian pharmacy owner and non-pharmacist told surveyors for the Minnesota Board of Pharmacy, "We won't have any problem getting drugs. We have creative ways to get them."[6]

■ U.S. Surgeon General Richard Carmona is very concerned about "the extremely robust counterfeiting system" for prescription drugs, adding that counterfeiting "would pose significant challenges to any importation plan that we may be considering in the future." Carmona is the nation's top doctor, charged with guarding public health. He also chairs the federal government's task force on prescription drug importation.[7]

Warnings about Canadian Drug Imports

■ Canadian health authorities have warned the U.S. that Health Canada will not take responsibility for the safety of drugs exported from Canada to the United States.[8]

■ "Canadian authorities do not inspect medicines that are transshipped through their country bound for U.S. consumers, which opens a huge loophole for counterfeiters to sell us fake medicines masquerading as Canadian prescription drugs."[9]

■ Former FDA Commissioner Mark McClellan warned drug importation "creates a wide channel for large volumes of unapproved drugs and other products to enter the United States that are potentially injurious to public health and pose a threat to the security of our Nation's drug supply."[10]

■ The Illinois Pharmacists Association warns, "The medicine you buy from across the borders may be unsafe and ineffective." This ad ran immediately after Gov. Rod Blagojevich (D-Illinois) claimed his study of drug imports found "Canada's drug regulation and distribution system met American standards in every way."[11]

Savings Potential?

■ The commission that administers health insurance for state employees and retirees in Massachusetts found the state would save $10.4 million a year by purchasing lower-cost prescription drugs from Canada. But the commission recommended against moving forward with the plan, saying the savings would shrink to $1.4 million after waivers of copayments to incentivize participation by employees and loss of drug company rebates. And, the commission said, even the $1.4 million potential savings would not be worth the liability risks.[12]

■ Canada spent a total of $14.6 billion on prescription drugs in 2003, compared to more than $160 billion in the U.S. With Canada's market less than 10 percent the size of the U.S. market, it is unrealistic to expect to run a significant part of the U.S. drug supply through Canada to have its price controls imposed, and then have the drugs shipped back to U.S. consumers.

■ "It is likely that the intended cost savings for consumers would be absorbed by fees charged by exporters, pharmacists, wholesalers, and testing labs," according to FDA Commissioner Lester M. Crawford.[13]

Liability

■ Borderless drug stores, including those in Canada, require consumers to sign waivers that hold the seller harmless from any legal responsibility for the quality or effectiveness of the drugs sold. States that promote illegal drug importation programs, such as Minnesota and Wisconsin, say on their Web sites that they expressly disclaim "any and all liability from such importation or reimportation or the use of any products so acquired."[14] The reason is obvious: There is no realistic way to verify the safety of these drugs imported through Canada and other countries.[15]

■ "The bottom line is that [the state] will benefit by putting the drugs in the 'stream of commerce' and therefore must also bear the risk of loss if these drugs result in injuries," wrote Shikha Dalmia for Tech Central Station. The Illinois Supreme Court has recognized that "when a city creates a hazardous condition and someone is injured as a consequence, it must respond in damages, just as others are required to do."[16]

Impact on Investors

■ Minnesota Secretary of State Mary Kiffmeyer voted against Governor Tim Pawlenty's resolution to sell off Pfizer shares in an attempt to pressure the drug company to lower prescription drug prices. Kiffmeyer said that although efforts to reduce prices for U.S. residents are "laudable," the use of "funds that belong to state employees and retirees to pressure drug companies" is "not consistent with the board's fiduciary duty."[17]

■ Daniel Clifton, executive director of the American Shareholders Association, said such a move would devalue the holdings of more than 10 percent of the state pension fund. "The [drug] cost issue has become a political football with no real solutions being provided," said Clifton.[18]

Grace-Marie Turner is president of The Galen Institute. Her email address is **gracemarie@galen.org**. *Conrad F. Meier is managing editor of* Health Care News. *His email address is* **meier@heartland.org**.

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Blagojevich "Playing a Shell Game with People's Lives"

Prescription drug importation from Europe would open Illinois to counterfeiters, smugglers

by Allen Fore

Illinois Governor Rod Blagojevich announced on April 20 that he is sending a task force overseas to study whether the state should import prescription drugs from Europe.

"There's a big world out there," said Blagojevich. "I am instructing our special drug advocates to study how people in Illinois can import prescription drugs not only from Canada, but also from Europe. Because in Europe, prices are even lower than they are in Canada."

European drugs are less expensive, but also less safe, warn many experts.

"The governor is playing a shell game with people's lives," said Joseph L. Bast, president of the nonprofit, nonpartisan Heartland Institute. "First his marble was under the Canadian shell. Now that's been exposed, so he's shifted his marble to the European shell.

"Where will the marble go next—Africa?"

While disturbing, the governor's move is not surprising, said Bast. Several Canadian-based Internet pharmacies recently announced they would be filling prescription orders through Europe, because Canadian drug supplies are insufficient to meet demand. Canada manufactures very few drugs domestically and currently imports 40 percent of its drugs from countries other than the United States.

According to Industry Canada, a department of the Canadian federal government, Canadian imports from Singapore increased by 30 percent between 2002 and 2003; from Ecuador, nearly 200 percent; and from Iran, more than 2,700 percent.

That, noted Conrad F. Meier, is cause for grave concern.

"America's huge market for prescription drugs is a tempting target for counterfeiters," noted Meier, who is managing editor of *Health Care News*. "We knew all along Canadian drug supplies wouldn't be sufficient to sustain the importation program Governor Blagojevich has proposed. The smugglers and counterfeiters know that, too."

The World Health Organization estimates up to 8 percent of the world's drug supply is counterfeit. In Africa and Asia, that figure reaches 25 percent and more.

Noted Meier, "Eastern Europe is a growing source of counterfeit drugs. Operations producing millions of pounds' worth of fake pills have been exposed in Poland, Bulgaria, and Turkey—all three of which are on the verge of joining the European Union."

"Drug importation will create a two-tier system of drug quality in the U.S. One tier will be for those who can afford to pay for safe, American-made, FDA-inspected drugs. The other will be for low-income people—minorities and the elderly poor—who will be exposed to dangerous counterfeit drugs."

LEE WALKER

Importation raises serious concerns the governor has failed to address, noted Lee Walker, director of The New Coalition for Economic and Social Change, a Chicago-based black think tank.

"Drug importation will create a two-tier system of drug quality in the U.S.," said Walker. "One tier will be for those who can afford to pay for safe, American-made, FDA-inspected drugs. The other will be for low-income people—minorities and the elderly poor—who will be exposed to dangerous counterfeit drugs."

Allen Fore is vice president - public affairs for The Heartland Institute. His email address is **fore@heartland.org**.

INTERNET INFO

The Web site of The Heartland Institute offers more than two dozen documents addressing prescription drug importation.
http://www.heartland.org/PolicyBotTopic.cfm?artTopic=530

HSAs

Continued from page 1

self-only policies can set aside as much as $2,600 in their HSA, while families can set aside as much as $5,150 a year.

HSAs in Practice

Health insurance specialists acknowledge the merits of HSAs but maintain several important issues remain to be ironed out.

"What we're finding mostly is although these plans impose a lot of risk on the insured, the premiums just do not warrant the risk," said Deborah Mijal, an employee benefits consultant with Granite Group Benefits in Manchester, New Hampshire. "They could probably get an HMO and still have a competitive rate."

Nevertheless, Mijal sees HSAs playing a big part in that state's health insurance picture, because employers are currently bearing too much of the cost for employee health care. "For employers this is their second highest expense," Mijal said, adding, "HSAs are great but they need to be priced accordingly."

Assurant

Assurant, formerly Fortis Health of Milwaukee, sold the first individual medical HSA policy on New Year's Day.

"We're seeing a very strong interest and response from insurance agents and consumers," said Rob Guilbert, Assurant's vice president of corporate communications.

Assurant says the premium savings on a high-deductible HSA plan is 50 percent or more versus a typical low-deductible plan. Assurant, like other providers, touts the tax advantages: Contributions to the HSA are not taxed, interest earned on money in the HSA is not taxed, and expenditures from the account for qualified health expenses are tax-free.

Guilbert believes HSAs will set the standard and eventually dominate the market, once the financial benefits, such as reducing monthly premiums, and the system-wide benefits of putting consumers in control of their own health care spending are better recognized.

"This type of consumer choice model will definitely be the primary model for health insurance," Guilbert said.

To illustrate his point, Guilbert described the HSA's impact on a hypothetical family in Ohio, with two 37-year-old adults and two children. With traditional insurance and a $500 co-pay, Guilbert said, the family would expect to pay a monthly premium of $600—a total of $7,200 a year in insurance premiums alone.

If instead the family was insured under the HSA model with a $5,000 annual contribution to the account, the monthly premium would fall to $250—just $3,000 a year. HSA tax savings (assuming the household is in the 25 percent tax bracket) add up to $1,200. Total savings for the family are $5,400, according to Assurant.

In December 2003, President George W. Bush launched health savings accounts, increasingly popular among consumers and insurance providers alike.

CareFirst Blue Cross and Blue Shield

CareFirst Blue Cross and Blue Shield, the top carrier in the Mid-Atlantic region, has announced plans to add HSAs to its consumer-directed health care plan portfolio. The company expects to sell the HSA product to large and small employer groups.

"We feel HSAs will sell well in our individual markets and we plan to pursue it," said Cindy Otley, a product director with CareFirst in Owings Mills, Maryland.

To date, the larger employers in CareFirst's coverage area have shown the most interest in HSAs. Such employers recognize they compete for employees with other firms, and HSAs are viewed as a substantial benefit that can be used to attract and retain qualified employees.

Otley says new consumer-directed health care products, similar to the HSAs, are on the horizon. Providers will be trying to get innovative and more competitive about how to deal with increased costs.

"More and more costs are being shifted to the consumer," she said. "We think the market is steadily going to move in this direction using these types of accounts."

Caution Expressed

One disadvantage with HSAs, according to Granite State's Mijal, is educating consumers on how to use them. "We're leaving a lot of decisions back on the consumer where they should be, but it's a whole new way of assessing health care and being educated," she said. "At our level we educate the employer and employees when working with them to put together comprehensive benefits plans in where risk is, where to take risk as well as what they can do to save money."

HSAs aren't for everyone. Small business owners and individuals should check first with their tax professionals to see if these high-deductible health insurance policies are a good fit.

Stephen Parezo is writer and editor for Fiducial*, an international provider of small business services. This article is reprinted with permission. For more information, tips, and resources, log on to* **http://www.fiducial.com**.

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Obesity

Continued from page 1

a study showing Americans born today have a 1 in 3 chance of developing obesity-related diabetes. Among Hispanics and blacks, the risk is 1 in 2.

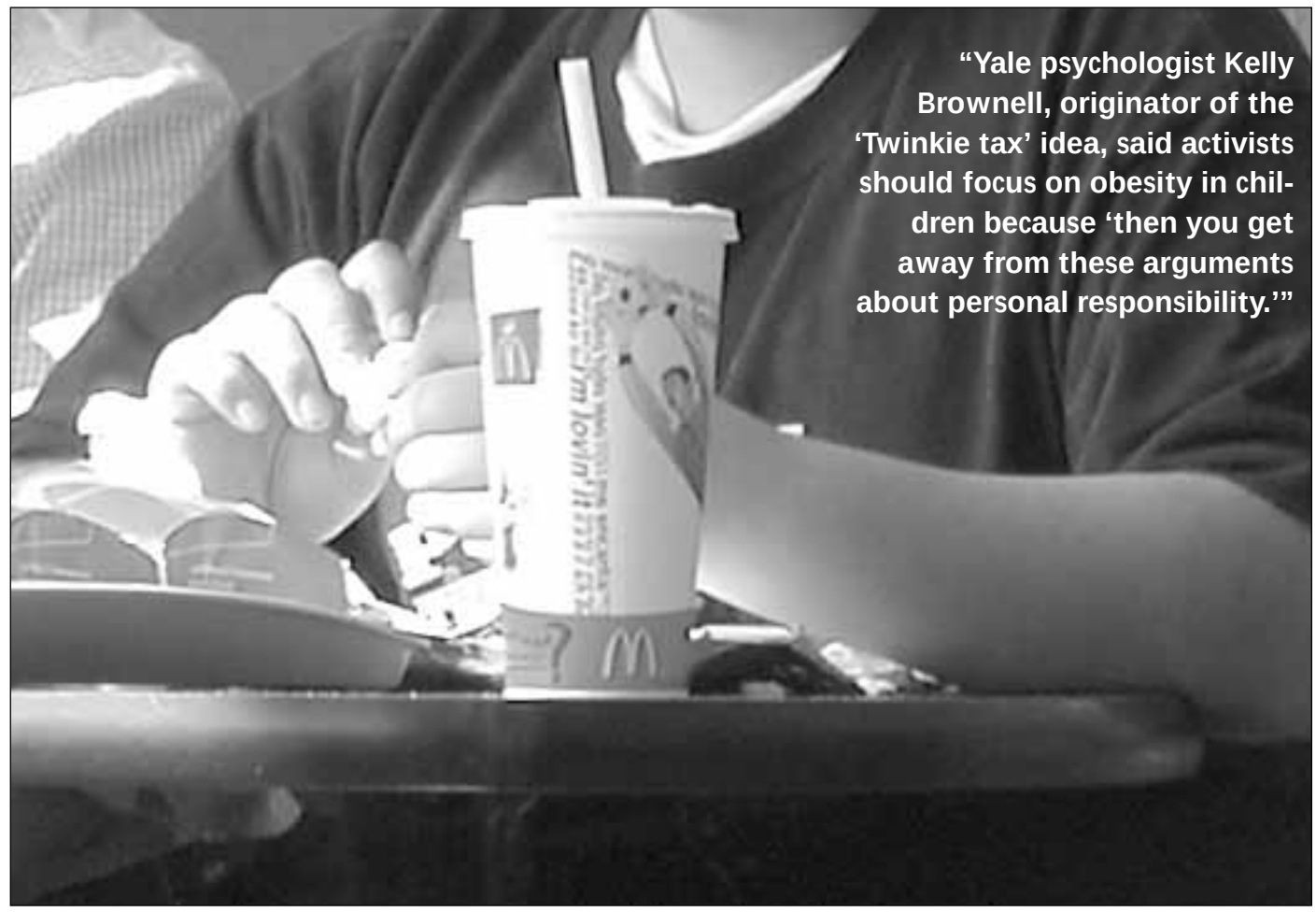
"The House should follow the Senate's lead," said Frist, "and act to pass the Improved Nutrition and Physical Activity Act (IMPACT), introduced by Representatives Mary Bono (R-California) and Kay Granger (R-Texas). The health of our nation is at stake if we don't act now."

Frist introduced the IMPACT Act in the Senate last year with colleagues Jeff Bingaman (D-New Mexico) and Christopher Dodd (D-Connecticut). Among other things, the act calls for training grants to teach health profession students how to treat and prevent obesity; community grants to promote physical activity and obesity prevention; obesity education programs for young people to help them develop healthy habits early; studies of the causes of obesity; and authority to use mass media to carry out a campaign to promote physical activity in young people.

The legislation has passed the Senate by unanimous consent and is pending in the House Energy and Commerce Committee. An earlier version of the bill died in that committee last year.

Frist also has introduced the "Closing the Health Care Gap Act," which would create within the Department of Health and Human Services an Office of Minority Health. The office would work with federal agencies and the Surgeon General to study health disparities, develop strategies to address them, and increase awareness of the problem among health care providers, health plans, and the public.

The Gap Act also provides for health care access and awareness grants; tax credits and other means to reduce the number of persons without health insurance; increased federal support for historically black colleges and universities; and demonstration projects to test model curricula for minority cultural awareness and sensitivity among health professionals.


"Yale psychologist Kelly Brownell, originator of the 'Twinkie tax' idea, said activists should focus on obesity in children because 'then you get away from these arguments about personal responsibility.'"

Zuma Press

Politics and Yet Another Program?

The legislation is being viewed with a jaundiced eye by some health policy experts.

Grace-Marie Turner, president of the Galen Institute, told *Health Care News* she worries about the Gap Act "institutionalizing" racial thinking in medicine.

"This legislation is making it a political issue rather than a medical issue," Turner said. "As far as obesity, I think the government has a positive role to play in public education. If they can do some research and education, that's fine. But once you set up new programs, they have a life of their own."

Dr. Sally Satel, resident scholar at the American Enterprise Institute, said she believes the Gap Act is unnecessary.

"What's good about it could be done through HHS," Satel told *Health Care News*. "The good things are health literacy, demonstration projects, data collection. But the CDC could collect that data.

"Some other aspects of it, I think, miss the point," Satel continued. "I don't think diversity of the health workforce is an especially important element in reducing the health care gap. And if anyone could clearly define 'cultural competence,' I'd be grateful."

Satel said there is no need to create federal programs to help medical personnel adjust to cultural differences.

"Whenever I've spoken to people who work near Indian reservations or with immigrants, they're aware of the need to learn the local anthropology and are aware of cultural differences. You adapt organically to your patient population," Satel said.

Cato Institute policy analyst Radley Balko agreed. "My first reaction is that it's not the government's responsibility," Balko said. "As far as the racial disparities, I would suggest these are more class issues than race issues."

Balko has other objections to Frist's legislation.

"There is a more fundamental problem, which is throwing government grants at these problems and not letting them sort themselves out," he said. "My problem [with Congress's reaction to the obesity epidemic] is that they are abandoning federalism. The way they should be attacking this is by giving people ownership over their own health care.

"When you have responsibility for your own health care, you take better care of yourself. They're inching our system more and more toward socialism. They passed this 'cheeseburger bill' [to block lawsuits that accuse fast-food restaurants of causing obesity]. Well, if I'm paying for my neighbor's heart attack, I'm likely to support those lawsuits. My neighbor's excess weight becomes my business."

Fat Police

Your neighbor's health as your business was a repeated theme at the annual meeting of the American Public Health Association held in San Francisco last November. More than 13,000 members attended, and, according to an account by Kelly Jane Torrance published December 23, 2003 at Reasononline.com: "Speaker after speaker scorned the notion that individual Americans are responsible for their own choices."

"My problem [with Congress's reaction to the obesity epidemic] is that they are abandoning federalism. The way they should be attacking this is by giving people ownership over their own health care."

RADLEY BALKO, CATO INSTITUTE

She cited Margo Wootan of the Center for Science in the Public Interest as saying, "We have got to move beyond personal responsibility," and Skip Spitzer of the Pesticide Action Network, who said "the idea of 'personal responsibility'" is merely "a cultural construct."

Yale psychologist Kelly Brownell, originator of the "Twinkie tax" idea, said activists should focus on obesity in children because "then you get away from these arguments about personal responsibility."

Torrance also cited Public Health Institute lawyer Edward Bolen, who "called for tobacco-style restrictions on food, including price controls; minimum age requirements to buy certain foods" and even bans on producing certain foods.

Diabetes Key Concern

The CDC study, reported in the October 2003 issue of the *Journal of the American Medical Association*, concluded 400,000 deaths in the U.S. in 2000 were attributable to obesity and lack of exercise. Ten years earlier, obesity accounted for about 300,000 deaths. By comparison, tobacco use (mainly smoking) accounted for about 435,000 deaths in 2000, according to the study.

A chief obesity-related ailment is diabetes. American females born in 2000 have a 38.5 percent risk of developing diabetes, cutting life expectancy by 14.3 years if the disease is diagnosed by age 40, according to the study. Males born in 2000 have a 32.8 percent risk of developing diabetes, shortening life expectancy by 11.6 years if diagnosed by age 40.

Among minorities, the risks are disproportionately high. The CDC report says female Hispanics have a 52.5 percent risk of diabetes from birth; male Hispanics a 51.9 percent risk. The risk is 49 percent for black women and 41.4 percent for black males.

White females have a 31.2 percent risk and white men a 26.7 percent risk.

Dr. K.M. Venkat Narayan, a diabetes epidemiologist at the CDC, conducted the study using data from the annual National Health Interview Survey of about 360,000 people from 1984-2000, from the U.S. Census Bureau, and from a previous study of diabetes as a cause of death.

"I think the fact that the diabetes epidemic has been raging has been well known to us for several years. But looking at the risk in these terms was very shocking to us," Narayan told reporters when releasing the study.

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MY **TURN**

"Cover the Uninsured" a Starbucks Grande

Conrad Meier

"The last thing I need [in the morning] is a tasteless blend of misinformation served up "Grande" by Starbucks and disguised as a 'public service' announcement."

The first thing I need in the morning is my favorite blend of Starbucks coffee in my Grande cup.

The last thing I need is a tasteless blend of misinformation served up "Grande" by Starbucks and disguised as a "public service" announcement.

If you missed the full-page ads in the May 5 issue of *USA Today* and other newspapers promoting this year's "Cover the Uninsured Week," you missed a classic example of Orwellian newspeak.

This is not to say our health care finance system is perfect. It isn't. But the solutions embedded in the Cover the Uninsured Week project suggest more government involvement rather than less and ignore the rapidly growing trend away from bureaucratic health care and toward consumer-directed care.

44 Million Uninsured?

"Cover the Uninsured Week" is another product from The Robert Wood Johnson Foundation (RWJ), the liberal advocacy group that has done so much to confuse and cripple the health care reform movement. This year's lead spokesperson Noah Wyle, the actor who plays Dr. Carter on the TV drama "ER," recites the questionable data supplied by RWJ, claiming "nearly 44 million Americans go without health care coverage of any kind."

Wyle refers to his TV scripts as if they were fact, saying, "I've spent the last decade playing the role of a doctor on a program that depicts the plight of uninsured people who arrive in a Chicago emergency room, seeking medical care they can find nowhere else." Make-believe is rarely a reliable guide for making real-world public policy.

According to the nonpartisan Congressional Budget Office (CBO), the uninsured figure most often cited in news media reports and television series is inflated by counting people who are uninsured only temporarily. According to the CBO, roughly 25 million Americans go without health insurance for 12 months or more.

A sizeable part of the increase in the number of uninsured people in the U.S. in recent years is the result of illegal immigration. Roughly 9 million documented and undocumented aliens are generally included in the uninsured estimates. Many hesitate to participate in a government-program that could establish a paper trail for immigration authorities. Cultural mores, folkways, and language barriers also conspire to keep these people uninsured.

Far Cry from a Crisis

Data from three federally sponsored national surveys—the Survey of Income and Program Participation (SIPP), the Medical Expenditure Panel Survey (MEPS), and the National Health Interview Survey (NHIS)—reveal the number of uninsured at a particular point in time.

All three surveys conclude that at any given time during a year, uninsurance is a much smaller problem than we are led to believe. For example, only about 30 percent of non-elderly people who become uninsured in a given year remain uninsured for more than 12 months. Nearly 50 percent regain health insurance within four months.

In other words, even the CBO estimate is too high by nearly half. While 44 million Americans might be without insurance for at least a day, somewhere in the neighborhood of 20 million are uninsured for four months or less. Only 14.6 million go for more than 12 months without insurance. We can say that's still too many uninsured ... but it's a far cry from the crisis we're led to believe exists.

Notoriously Inaccurate

Population surveys are prone to reporting and statistical errors, making data derived from them inherently unreliable. Controversy regularly attends reports from the decennial Census Bureau surveys for exactly that reason.

Some segments of the population may be under-represented in surveys, leading to the possibility of an undercount. Over-stating is also a possibility, if estimates are extrapolated from samples too small or insufficiently representative of the population as a whole. And even when populations are properly surveyed, their answers may not be accurate. Misstatements, intentional or not, plague population surveys.

Research I conducted while at the Center for Advanced Social Research at the University of Missouri-Columbia discovered many Medicaid recipients say they don't have insurance coverage, when in fact they do—they just don't consider Medicaid to be insurance. Some people counted among the uninsured are eligible for insurance through Medicaid and the State Children's Health Insurance Programs, but have not applied. They will be enrolled when they arrive at a clinic or hospital seeking treatment.

Uninsured Have Access to Care

RWJ would have us believe that being without health insurance is the same as being without health care "of any kind." They might as well tell us being without car insurance means we are without transportation. Just as there are many ways to get around that don't require insuring an automobile, so too is there public access to medical care without health insurance.

Public and private hospitals, community health centers, local health departments, free clinics, faith-based programs, emergency rooms, and Veterans Administration hospitals provide billions of dollars' worth of free care to the uninsured every year. Private and public care-givers provide billions of dollars a year more in services to uninsured patients who pay cash for care, a growing trend.

Starbucks somehow got snookered into sponsoring this year's Cover the Uninsured week. It's time for them to wake up and smell the coffee.

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